REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

CORRECTED

At Orange on Wednesday, 2 November 2016

The Committee met at 9:00 am

PRESENT

The Hon. P. Green (Chair)

Mr J. Buckingham
The Hon. C. Houssos
The Hon. T. Khan
The Hon. N. Maclaren Jones
The Hon. W. Secord
The Hon. B. Taylor

The CHAIR: Welcome to the third hearing of the Select Committee on the Off-protocol Prescribing of Chemotherapy in NSW inquiry. Before I commence, I acknowledge the Gadigal people who are the traditional custodians of this land and I pay respects to the elders past and present of the Eora nation, and extend that respect to other Aboriginal people present or those who may be joining us today on the internet. Today the Committee is examining off-protocol dosing of chemotherapy in New South Wales including at Orange and Bathurst hospitals. As you are aware Dr John Grygiel worked as a fly in, fly out medical oncologist at Orange and Bathurst hospitals. Today's hearing is the third of four hearings we plan to hold for this inquiry. Today we will hear from senior officers from Western NSW Local Health District.

Today's hearing is open to the public. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, I inform members of the media who are here or who may be joining us that while Committee members and witnesses may be filmed or recorded, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that they are not authorised to film outside this hearing room without permission. You may not film witnesses coming into or out of the hearing. I remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. The guidelines for broadcasting of proceedings are available from the secretariat.

There may be some questions that a witness could only if they had more time or with certain documents at hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. I ask witnesses to please be careful when using individual names during the hearing in order to avoid unnecessary harm to the reputation of people. Pleasure ensure your comments are relevant to the terms of reference. I also remind witnesses to respect the privacy of individual patients. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at this hearing. So I urge witnesses to be careful about any comments they may make to the media or to others after they complete their evidence, as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation.

Some of the content of this hearing may be distressing, especially for patients and family members. I note that the local health district have brought some counsellors with them today for anyone who feels distressed. I understand that the chief executive officer of the local health district will make a further statement about that shortly. Witnesses are advised that any messages should be delivered to Committee members through the Committee secretariat. Finally, would everyone please turn off their mobile phones or set them to silent for the duration of the hearing.

Mr SCOTT McLACHLAN, Chief Executive Officer, Western NSW Local Health District, sworn and examined

Dr ROB ZIELINSKI, Medical Oncologist, Central West Cancer Care Centre, Orange Health Service, affirmed and examined

Ms RUTH JONES, Director, Cancer Services Innovation, Western NSW Local Health District, sworn and examined

Ms DI WYKES, Director, Clinical Governance, Western NSW Local Health District, affirmed and examined

Ms SUE PATTERSON, General Manager, Bathurst Health Service, sworn and examined

Ms CATHERINE NOWLAN, General Manager, Orange Health Service, sworn and examined

The CHAIR: Do you wish to make an opening statement?

Mr McLACHLAN: Thank you for the opportunity to address the Committee this morning. First, I sincerely apologise to the patients and their families who have been affected by this matter. If any content is discussed today that is distressing to anyone, we have social work support available here in the facility. We have worked very hard to develop our cancer services and to deliver care to patients closer to home using state-of-the-art technology, drugs and equipment. More than 1,000 patients receive their cancer care in western New South Wales every year. It was just five years ago that 44 per cent of the patients in this region had to travel to get care. Today that figure is less than 7 per cent. We have been through an amazing transformation. The past decade has seen unprecedented investment in infrastructure, services, and facilities, allowing us to transition from being reliant on fly, in fly out services. There has been provision of locally based cancer services with only those patients with rare or complex cancers needing to be referred to a metropolitan facility.

On being made aware of off-protocol chemotherapy prescribing by one doctor, we took immediate action and worked with relevant authorities to review the impact on patients in western New South Wales. Since then, we have worked with any affected patients and their families, and our commitment to them remains unwavering. For any community members concerned about their care, a cancer inquiry line remains open and available for support. We have cooperated fully with all investigations, including the inquiry under section 122 of the Health Services Act and the Health Care Complaints Commission inquiry. Since the release of the section 122 review in September, we have made significant progress in the implementation of all of the recommendations.

In 2015, our organisation undertook a staged implementation of the electronic medical records system called MOSAIQ, which also helps us prescribe for patients. We were the first rural region in New South Wales to implement such a system, and we pride ourselves on being leaders in that case. Past practices within our organisation, in particular recordkeeping, were unacceptable. MOSAIQ has transformed our ability to electronically prescribe treatment and drugs with many safeguards in place. It contains chemotherapy dosing protocols, which are continually updated to reflect evidence-based best practice. We have also recently recruited a number of oncology pharmacists, who play a crucial role in systematically reviewing all chemotherapy orders prior to administration. Any variation in chemotherapy dosing outside of the guidelines is accompanied by an explanation at the point of initial prescribing.

Clinicians have an ethical and professional responsibility to provide individual-based care and best practice cancer treatment for patients. These systems ensure that that is now monitored and is truly evidence-based. Specialists in oncology now conduct monthly reviews of prescribed chemotherapy to ensure that appropriate doses are provided to all of our patients. Our multidisciplinary teams in cancer care also now work together on a regular basis to oversee patient care. Our region-wide cancer clinical stream, made up of medical, nursing, and allied health clinicians from across the region, has seen better engagement between clinicians and management teams.

Creating an environment where staff are confident to speak up to ensure the safety of our patients remains our high property into the future. This has been an exceptionally challenging, distressing and regrettable time for everybody involved—particularly for the patients and their families. We are sincerely sorry for any pain and anxiety caused. What the local cancer team has achieved and built over the past decade for the community has been inspiring. I thank the staff for their unwavering care and for supporting patients and their families through what has been a very difficult time for all. We remain happy to assist the Committee in any way we can.

The CHAIR: Can you walk the Committee through what happened after you heard about or found out about Dr Grygiel's flat dosing? What happened from that first point to where you are now?

Mr McLACHLAN: Certainly. I am very happy to do so.

The Hon. WALT SECORD: Can we have dates?

The CHAIR: If possible, can you supply dates? It is very important that we get the right date, as in day and month, and also the year.

Mr McLACHLAN: Certainly. If you are happy, Mr Chairman, I will play a coordination role given that we have a big panel to answer questions.

The CHAIR: Mr McLachlan can direct questions to the appropriate person.

Mr McLACHLAN: We first became aware of the issue on 18 February 2016 as a result of the *7.30* report. Immediately the day after we gathered a team comprising some of the most senior clinicians and management people to help understand the potential scale of the issue in western New South Wales. On that day, we contacted the Clinical Excellence Commission, the Cancer Institute, the Health Care Complaints Commission, and a range of other people to try to understand the scale of the issue, and to understand Dr Grygiel's visits over some years and the type of patients he treated. First we needed to help patients through what we knew would be a very concerning series of events. We took steps very early to set up a cancer inquiry line. The director of clinical governance and some of our most senior clinical governance people manned that line from day one.

We took steps within the next week to understand the group of patients who might have been affected. We undertook an initial review and started to understand the issue facing us. All of our considerations revolved around the patients in our region, knowing the fear and concern that cancer brings to patients and their family. Throughout that week we started much more dialogue with NSW Health, the Cancer Institute, and the Clinical Excellence Commission. They were our guiding partners in understanding the steps we needed to take. We started to document all of the concerns that we were becoming aware of, and took steps to address them.

The CHAIR: Did anyone call Dr Chant with initial news about what you found? Did anyone call her directly and have a conversation with her about possible steps that could be considered?

Mr McLACHLAN: Yes, we certainly did.

The CHAIR: On what date did that happen?

Mr McLACHLAN: I believe that happened on 19 February, the day after the *7.30* report program was broadcast. We made calls on 19 February to Dr Chant, the Clinical Excellence Commission, the Cancer Institute, and the Health Care Complaints Commission.

The CHAIR: What sort of conversations were involved?

Mr McLACHLAN: I might need to rely on Ms Jones, who had that initial conversation with Dr Chant, to answer that question.

Ms JONES: I spoke with Dr Chant about the fact that Dr Grygiel had been a fly in, fly out medical oncologist. He was the only one in Bathurst and Orange. For Bathurst it was from 1989 and for Orange it was from 1990 through to 2012. He then provided video-conferenced consultations for follow-up patients until February 2013.

The Hon. TREVOR KHAN: Do I take it that until the *7.30* report program was broadcast you had no knowledge of the issue?

Mr McLACHLAN: That is correct.

The Hon. TREVOR KHAN: So no-one at St Vincent's Hospital had contacted you to tell you that they were undertaking an external investigation?

Mr McLACHLAN: That is correct.

The CHAIR: No nurses had reported that adverse dosing was occurring?

Mr McLACHLAN: We had no formal reports.

The Hon. WALT SECORD: Did you have any contact or any calls with Dr Grygiel during that period?

Ms WYKES: No, not to my knowledge.

Mr McLACHLAN: No.

Mr JEREMY BUCKINGHAM: Mr McLachlan, when you say "formal reports"—

The Hon. TREVOR KHAN: That has become an issue.

Mr JEREMY BUCKINGHAM: It has become an issue for the Committee.

Mr McLACHLAN: Sure.

Mr JEREMY BUCKINGHAM: Were there any other reports? Were issues raised in any other way by junior staff or other oncologists in the local health district [LHD] with management or the executive?

Mr McLACHLAN: We did not have any formal reports of a pattern of clinical care that was concerning.

The Hon. TREVOR KHAN: That is not what you were asked. You used the word "formal"—

Mr McLACHLAN: Sorry. We did not have any reports of a pattern of care. We certainly had reports about some of the behaviour that was concerning for other clinicians, but not formal reports of a pattern of care.

Mr JEREMY BUCKINGHAM: How did those reports manifest themselves? Were they just verbal reports? Can you expand on that?

Mr McLACHLAN: Generally they were reports of the conversations between staff about Dr Grygiel's attitude and way of interacting with staff.

The CHAIR: Were multidisciplinary team meetings held with Dr Grygiel?

Mr McLACHLAN: Ms Jones, could I ask you to talk to that?

Ms JONES: Yes, they were held. Our first multidisciplinary meeting, which was a formal metropolitan style multidisciplinary team meeting, commenced approximately 2004. It may have been 2003—I would need to check that. He participated in that. It was held at 7 a.m. on a Friday morning in Orange.

The CHAIR: Did you have regular patient case managing multidisciplinary team meetings where you looked at a patient, for instance, and discussed their care and the outcomes of their care?

Ms JONES: I guess for regional and rural areas there are the formal metropolitan models where treatment care is planned, but given the fly in, fly out nature of the services we had at that time we also had team meetings in both Bathurst and Orange around the care that each patient may have needed. So not every patient would have been discussed every time, but for patients for whom an assessment had been made that they needed additional care—it might have been for an allied health support; it may have been that we needed to follow up with the medical specialist—those sorts of meetings were held.

The CHAIR: In those sorts of meetings was it ever discussed with different patients about the dosage of carboplatin or any other drugs that they may be on as part of their care?

Ms JONES: Not to my knowledge, and that was certainly not the tone of the meetings—around dosage. It was around the supportive care of those patients.

The CHAIR: Would you find it unusual in a multidisciplinary team [MDT] for, say, a radiation specialist or a surgical specialist not to be aware of the treatment of a patient, particularly in the way of dosages and medication?

Ms JONES: I am going to hand that to Dr Zielinski, our medical oncologist.

Dr ZIELINSKI: I would not find it unusual in the sense that I am not sure what the radiation oncology delivery of the X-rays are and what the surgeon does, but you understand principles of the other specialists. That is the whole fundamental point of the multidisciplinary care of the patient. I would not think the individual dose is ideally discussed in an MDT.

The CHAIR: Thank you.

The Hon. TREVOR KHAN: Dr Zielinski, we started this exercise on the basis—and I think I know the direction of the questions the Hon. Walt Secord wants to ask—that Dr Grygiel was doing what has been loosely described as off-protocol dosing. It seems as it has gone on, including in his evidence yesterday, that the flat dosing reflected his use of carboplatin as a sensitiser for the purposes of improving the radiotherapy as opposed to using it for chemotherapy. It strikes me as odd that if someone was using it for radiosensitivity that would not have been a matter of discussion in a multidisciplinary environment because the medical oncologist is using it to supplement the radiotherapy as opposed to for its own purpose. Am I off beam in saying that there would have to be some interaction between sub specialties at that point?

Dr ZIELINSKI: I think so and I think the onus is obviously on the radiation oncologist to understand what the dose of chemotherapy is, because they are clearly in the driver's seat. But the MDT has lots of functions. The critical discussion is what the best treatment plan is and then you have to rely on other checks and balances like pharmacists checking doses to say, "If I have chosen a protocol, is that the correct one and is it being delivered to the patient?"

The Hon. TREVOR KHAN: That is the point, and I think we are on the same hymn sheet. If someone is essentially saying, "Look, chemotherapy is not the way to go here—it is primarily radiotherapy," irrespective of whether it is about specific dosage, that discussion about whether the primary emphasis is upon radiotherapy or chemotherapy would be the sort of thing one would expect to be discussed in a multidisciplinary environment.

Dr ZIELINSKI: I think not on a case by case basis. That discussion has to happen and that needs to be understood between the specialists: "This is our principle of how we treat chemo-radiotherapy patients. We use a dose of X drug at this many milligrams." Because often at MDTs you have not met the patient, so you might say, "I am going to give this dose of chemotherapy," and then you go and see the patient and they have other diseases or their personal choice is that they do not want the chemotherapy. So you have spent a lot of time in the MDT, where there is limited time, and that plan has now completely changed once you have tried to apply the plan to the individual patient. So I agree with you totally but I think the MDT space is not the best opportunity for that. I think there has to be a discussion between the specialists to say, "This is how I treat head and neck in chemo-radiotherapy protocols."

The Hon. WALT SECORD: I am Walt Secord, Labor's spokesman on health. Mr McLachlan, in your evidence earlier you made reference to concerns about Dr Grygiel's attitudes prior to the 18 February *7.30* report. What were those attitudes and concerns that were expressed to you or to the health district?

Mr McLACHLAN: I never met Dr Grygiel. He finished up in the district before I started. But the concerns that I have heard from staff were about an abrupt manner and that he was not comfortable being challenged.

The Hon. WALT SECORD: Do you mean he was not comfortable being questioned?

Mr McLACHLAN: Yes.

The Hon. WALT SECORD: And how did staff say he responded when challenged?

Mr McLACHLAN: I would have to rely on other people that might be able to help.

The Hon. WALT SECORD: Are there other witnesses who could enlighten us?

Mr McLACHLAN: Ms Jones, do you have any insights into this?

Ms JONES: I have had staff explain to me that there were days when he was more open and receptive and days when he was very much less open and receptive. Obviously at times that was difficult.

The CHAIR: Ms Patterson, I note that you are reaching for the microphone.

Ms PATTERSON: I was going to say that I had a nursing unit manager at Anson Cottage at Orange come to me and express concern about Dr Grygiel's interaction with her—not about treatment but about the personality of Dr Grygiel.

The CHAIR: Are you suggesting it was a personality clash?

Ms PATTERSON: He was at times exactly what Ms Jones has said—difficult to get on with. I spoke with Dr Grygiel about his manner with staff and expected him to engage more professionally with staff.

The Hon. TREVOR KHAN: Were those noted as specific complaints being made by staff?

Ms PATTERSON: No. It was informal. I did diarise it in my diaries but it was not as specific as, "It occurred at this point in time." There was not a pattern that I was aware of at this point. There was nothing. It was merely noted in my everyday diaries that I have.

The Hon. TREVOR KHAN: I am going to come to Ms Jones and ask her the same questions in a moment, but was it on one occasion or more than one occasion that that style of concerns, as it has been described, were raised?

Ms PATTERSON: I only had one occasion.

The Hon. TREVOR KHAN: Ms Jones?

Ms JONES: It was on more than one occasion and when I asked a staff member if they would like to make a complaint for us to follow up the answer was no.

The CHAIR: To make it clear, let's separate it from Dr Grygiel. Did you have other experiences with other specialists that had that same sort of presentation or personality with their treatment or on any other level?

Mr McLACHLAN: I am happy to answer. It is something that we continue to tackle right across the health system. It is something that we have no tolerance for as an organisation. We have a code of conduct with a set of values that we hold dear and part of that is respect between all clinicians. We have asked every single one of our teams to outline both their above-the-line and their below-the-line behaviours right across the whole of the organisation. In those below-the-line behaviours quite a few staff often articulate some of the behaviours that make them uncomfortable. That allows each staff member to call that in their team. It also allows the manager to step in and help manage those once they are better defined.

I am sure over the years that there have been clinicians in health industries right across the world that have had some of this attitude. I think what we are seeing is a dramatic change in the training of young clinicians in helping them to speak up and in helping to provide a culture in our environment that is much more open and inviting for younger clinicians to raise issues and escalate concerns. I think we are a long way from some of the days that we are talking about.

The Hon. WALT SECORD: Mr McLachlan, can we go back to the patients in the Central West, in Bathurst? Can you take us through how many patients at the moment and what is the status of the PBS matter that is still outstanding? Dr Grygiel operated here from 1989 to March 2013.

Mr McLACHLAN: I am very happy to. I might ask Ms Jones to talk to that, if that is okay.

Ms WYKES: As you know, in the section 122 report there were 28 patients identified; five of those patients received carboplatin flat dose 100 milligrams and 23 patients were identified as receiving off-protocol capecitabine, which is an oral chemotherapy agent. We do not have the results of the PBS data at this point in time. The section 122 inquiry requested that data. We made a previous request but did not get a response. We expect a response this week, according to David Currow.

The Hon. WALT SECORD: Can I take you to the report itself? Point 23 of the patient review section says that you collected a random sample of patients. Did you actually go through all the files or did you just fly in and grab a few files? What does a random sample of patients in the Central West mean?

Ms WYKES: We liaised with the section 122 inquiry. The section 122 inquiry put the criteria around what files were reviewed and what numbers were reviewed. I think in the report they make an explanation about the numbers of patients that were seen and they asked us for a sample from Bathurst and Orange.

The Hon. WALT SECORD: So those five patients is not a reflection of a complete review of all the cases, that is just five out of a random sample; it is not a comprehensive sample.

Ms WYKES: Do you mean the five flat dose carboplatin?

The Hon. WALT SECORD: Yes.

Ms WYKES: The five flat dose carboplatin were not necessarily part of the sample. The five flat dose carboplatin patients came from an analysis of the carboplatin prescriptions from our chemotherapy company that provides our chemotherapy from the time that they had reports available, which was the end of October 2010 until the end of 2013.

The Hon. WALT SECORD: You see where I am trying to go here? I am trying to get an indication if that 28, five and 23 is a reflection of all the patients, is it a comprehensive review or is that just a sample?

Ms WYKES: The five are from all of the available records for carboplatin—

The Hon. WALT SECORD: But in one part of your report here you say there are no records whatsoever.

Ms WYKES: I am sorry?

The Hon. WALT SECORD: I will let you finish your answer and I will come back to what I have just said.

Ms WYKES: The five carboplatin are from the analysis of all of the cases from our prescriber from the end of October 2010 until the end of 2013. The 23 capecitabine were identified by the section 122 inquiry from 97 patients and some of those patients came from the sample—I believe I would have to check the numbers in the report—and some of those came from the capecitabine prescriptions from our prescriber.

The Hon. WALT SECORD: Mr McLachlan, can I go back to record keeping? Point 70 of the report says that record keeping was poor and point 59 says Dr Grygiel claims that every patient in the Western Local Health District signed a consent form. However, there are no consent forms and there is no record keeping. Why do we have that situation? Are you confident that we will ever get to the bottom of the number of people affected by Dr Grygiel in the Central West?

Mr McLACHLAN: A couple of points. The issues that have come out around our record keeping are not acceptable to us, but we have taken some steps to—

The Hon. WALT SECORD: They are described as "poor".

Mr McLACHLAN: We have taken some steps to both make sure that if those records are available that we can track them down and provide them to understand the issues for those patients. We are going back and doing an audit of 300 records between Bathurst and Orange of outpatients between 2012 and 2014. In terms of the issues around the patient files that we delivered to the inquiry, there were only seven files where we were not able to find complete records out of the big number of files that we did deliver. So it is not a problem across all of those files, but there were issues in not having height and weight within those files. I do believe that was part of determining dosage and other things; it just was not able to be found in those files.

The Hon. WALT SECORD: Dr Grygiel insists that he got written consent from all his patients; however, there is not a single consent form. There is a major discrepancy between what he says and what the files show.

Mr McLACHLAN: We do not have those consent forms in any of our files.

The Hon. TREVOR KHAN: Does that mean that they were not there or does it mean that your record keeping is poor? What conclusion are we entitled to draw?

Mr McLACHLAN: To be honest, I would have to say that they were not there. There are certainly complete records that we have provided to the inquiry and we have reviewed ourselves.

The Hon. TREVOR KHAN: Let me put it another way. Does that mean they were never obtained?

The CHAIR: Can I just go to Dr Zielinski, who obviously has great experience in this area? Would there be an expectation that a person undergoing chemotherapy, in particular flat dosing, would sign a consent form or would it be a verbal agreement of treatment?

Dr ZIELINSKI: Writing a consent form and getting a patient to sign it I think is just part of the process. You need to prove that the patient understands what they are signing. I think that is the critical thing.

The CHAIR: So there is a consent form that is required in that situation?

Dr ZIELINSKI: In various places in centres I have worked with there have been consents and there has not been a written consent form. Everywhere I have worked and the people I have worked with consent patients. There is a difference between those two issues. You have got to prove to the patient, I believe, they understand what they are signing up for, and getting them a consent form the first time you meet them when you have delivered an immense amount of complex information maybe is not the best time to consent. Nurses also go through a checklist. eviQ has got a very neat checklist, which does talk about fertility, vascular access, all those other things, and that maybe is a much more appropriate time. So consent is a protracted process, I think.

The CHAIR: That is right. If your world is falling apart because you just heard about cancer and you are just wondering how you are going to hold together, it is easy to sign anything, is it not?

Dr ZIELINSKI: Correct, absolutely.

The Hon. TREVOR KHAN: I am not seeking to quibble with the Chair and I am not seeking to quibble with you, but what I am interested in, in part, is the veracity of some of the evidence that we have received. Dr Grygiel says everyone signed consent forms. Now whether that was informed consent or not we can worry about later, but what we want to know is when Dr Grygiel comes before us and says everyone signed a consent form, is that accurate or is it not; is it truthful or is it not? Those are the questions we have to have answered. Ms Jones was there at the time. Can you tell us whether consent forms were signed?

Ms JONES: All our patients when they first were attending an appointment with Dr Grygiel signed a consent for release of information and that enabled us to make referrals to the multidisciplinary team and for anyone else they may need in their care. There were no chemotherapy consent forms that were signed that we have any knowledge of.

Mr JEREMY BUCKINGHAM: From any practitioner?

Ms JONES: Dr Grygiel was our only medical oncologist in Bathurst and Orange.

Mr JEREMY BUCKINGHAM: But were there other oncologists that were practising in the LHD and did they have consent forms?

Ms JONES: Not that I am aware of. I would have to take that on notice because it is not that I am aware of.

The Hon. TREVOR KHAN: There were two questions there. Were there other oncologists practising in the area was question one; question two is did they have consent forms? Your answer relates to the first part or to the second part of the question?

Ms JONES: It relates to the second part of the question. The first part of the question is that we did have fly in, fly out medical support to Dubbo. And so we did have separate medical oncologists who were coming from Sydney to Dubbo. I would need to check whether they at that time were provided—

The Hon. NATASHA MACLAREN-JONES: Was the usual practice also outside oncology for a consent from to be kept with the records or with the physician?

The CHAIR: What was the usual practice?

Ms JONES: Was that for me?

Dr ZIELINSKI: I do not know what it was back then but I documented my letter that I have explained and the patient has consented to treatment, so I write that in my notes now, but I cannot comment about Dr Grygiel. I do not think the Committee should focus so much on a form to document or prove consent. I think it is a very complex involved process.

The Hon. TREVOR KHAN: Again we do understand the subtlety of it but we have got evidence and we actually want to know whether the evidence we have received has veracity.

The Hon. WALT SECORD: I take you back to page four of the Currow report which says that one person refused to be interviewed as part of the inquiry. Have you investigated that? Why did they refuse to participate in the inquiry?

Mr McLACHLAN: As far as I understand that is a staff member, that is an ex-nurse unit manager from one of our cancer services. We have provided opportunity for all of our staff to provide information. We certainly have not stood in front of that at all. So I cannot comment any further than that.

The Hon. WALT SECORD: Between March 2012 and March 2013 Dr Grygiel operated Telehealth from Nepean Hospital out here. You are shaking your head?

Ms JONES: It is was not from Nepean Hospital.

The Hon. WALT SECORD: The report says Nepean Hospital. From where did he operate?

Ms JONES: From St Vincent's and Macquarie University Private.

The Hon. WALT SECORD: So the report of Dr Currow is wrong; it is not Nepean Hospital?[1]

[1] Refer to footnote 2 for clarification.

Ms JONES: He was not at Nepean Hospital.

The Hon. WALT SECORD: Will you detail what Dr Grygiel did in the telemedicine? How did it occur? What happened?

Ms JONES: They were booked as clinics where he was in Sydney and our patients were mainly in Orange but there were some from Bathurst who attended their Cancer Care Centre and had an appointment. We had a nurse with them at this end and they were follow-up patients: there were no new patients that were seen by Dr Grygiel via telehealth in that time.[2]

The Hon. WALT SECORD: On page four of the report it says that Orange Hospital provided clinical space for Dr Grygiel. What did that constitute?

Mr McLACHLAN: I might have to ask Ms Nowlan to talk to that, but as far as I understand as a private practitioner coming in to run private clinics we quite often provide rooms for fly in, fly out clinicians. It is access to a room to consult with patients, access to administration and nursing staff in the delivery of chemotherapy.

The Hon. WALT SECORD: What is the status of the implementation of the 16 recommendations in the Currow report?

Mr McLACHLAN: We are making good progress on all of those recommendations. We have provided an update just recently to the Ministry of Health. We are having monthly meetings with the Ministry of Health to update them and make sure that there is strong governance around the implementation of those. I would be happy to ask Di Wykes to talk to the implementation actions if that would be helpful.

The Hon. WALT SECORD: Will you provide the Committee with the most recent update?

Mr McLACHLAN: Yes, certainly. Do you want us to talk to that now or to provide the document?

The Hon. WALT SECORD: Yes.

Mr McLACHLAN: There are a lot of recommendations.

The Hon. WALT SECORD: I have read through them. I will ask a quick question. Do you believe that the fly in, fly out arrangements involving Dr Grygiel resulted in lesser patient care in the Central West?

Mr McLACHLAN: I think fly in, fly out services have been a core part of rural health service delivery for a lot of years and it will be into the future. We have got a lot of fly in, fly out clinicians that come into our region and they are some of the best specialists in Australia and we welcome them to part of our teams. I think that it is something that we need to strengthen some of the governance around where we put together a task force to focus on that. We started that piece of work about 18 months ago looking at the north-west remote part of our region with high Aboriginal populations, high chronic disease rates and other issues that we know that we need the right specialist support to come in and support our local clinicians. We pay the Royal Flying Doctor Service $1.3 million a year to fly clinicians out to the north-west remote part of our region so that was a real consideration. How do we support those clinicians? Have we got the right clinicians coming in?

The Hon. WALT SECORD: I am asking specifically about the fly in, fly out arrangements involving Dr Grygiel.

Mr McLACHLAN: I think that happened over a lot of years. It was a time when we had a lot of other specialists come in. There is certainly a better solution now having local clinicians that we have now employed, three times more staff in Orange than we had five years ago. We have got local multidisciplinary teams that we were not able to assemble over those years. We have got local oncologists, pharmacists, nurses and other specialists that I think is a long cry from some of the fly in, fly out services.

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[2] In correspondence to the committee dated 28 November 2016, Professor David Currow, Chief Cancer Officer, NSW, and CEO, NSW Cancer Institute, responded to this evidence:

Ms Ruth Jones gave evidence to the Select Committee on 2 November 2016 (at pages 8-10 of the transcript) that there were a variety of arrangements in place between the resignation of Dr Grygiel in 2012 and the commencement of new medical oncologists in Orange in 2013. She advised that for new patients at Bathurst, telehealth was provided from the Liverpool Cancer Care Centre and new patients at Orange were travelling to Nepean. There was also a fly-in fly-out medical oncologist who travelled to the Local Health District to see patients who were not well enough to travel. Dr Grygiel saw no new patients; he saw follow-up patients at Orange and Bathurst through telehealth arrangements from Sydney. At no time did the [Section 122] Inquiry state that Dr Grygiel did this from Nepean. I refer the Select Committee to paragraph 12 of the Inquiry's Report on patients treated at Western NSW Local Health District.

The CHAIR: The point is what accountability structures are in place for fly-in, fly-outs? Do you have a comment on that?

Mr McLACHLAN: Across a number of different specialties we have got different arrangements. Specifically for Dr Grygiel he came in as a private practitioner, billed Medicare, wrote notes on his St Vincent's letterhead and did a lot of things as a private practitioner. So there is a grey area there what our responsibility is with that. But we held a contract with Dr Grygiel as an honorary medical officer. It is something that we continue to grow our ability to make sure that there is a contract in place that when clinicians come into our facilities that there is good, strong approaches around record keeping, around team conversations, around how they relate to community and patients. So I think it is something that we have still got a lot of work to do on.

The Hon. TREVOR KHAN: I think Dr Zielinski wants to say something.

Dr ZIELINSKI: I was responding to Mr Secord's question about was the care with the patient—

The Hon. WALT SECORD: Lesser—

Dr ZIELINSKI: Lesser. I completely do not think that is the case.

The Hon. WALT SECORD: You do not?

Dr ZIELINSKI: No, because I think access to cancer services has been proven all the time that the closer you can bring practitioners and the service to the patient they will uptake that service. So I think having a fly in, fly out physician is not your perfect model, and none of us would say that and I am proud of what we are doing now, but a lot of the patients still even I see, I try to get down to Sydney or from further parts in Orange. They do not want to come. They do not want to travel. I think by having a fly in, fly out service is far better than not having in a fly in, fly out service.

The Hon. COURTNEY HOUSSOS: I think the comparison is whether the fly in, fly out service is comparable to having a local doctor. Ms Jones, you said that during 2012 to 2013 Dr Grygiel had no new patients; they were all follow-up patients through Telehealth methods. What happened to the new patients who were diagnosed during that period?

Ms JONES: That was a difficult period for us. We had recruited medical oncologists to start in Orange in 2013 and Dr Grygiel had resigned from 2012. So we had a variety of arrangements that we put in place to try to ensure that our patients received good care. For Bathurst we had Telehealth coming from Liverpool Cancer Care Centre and for Orange we had patients who were travelling to Nepean. We funded Nepean to employ a medical oncologist to provide a specific clinic for our Central West patients. But we also had a fly in, fly out medical oncologist who was able to come, and I believe it was once a month, to see the sickest of our patients because they obviously would not be well enough to travel. So it was a difficult jigsaw puzzle at that time.

The Hon. WALT SECORD: Ms Jones, I am sorry to say, you seem like a sincere person who is a bit sad about being at these proceedings. How did you feel when the Dr Grygiel matter came to public attention? I see that you are a person who cares about your patients and patients in the health system. How did you feel?

The Hon. TREVOR KHAN: I am sure everyone at the table does.

Ms JONES: Well, we were devastated. I personally was devastated. I had no knowledge that he was not prescribing the most appropriate chemotherapy for every patient and I think it is very difficult. He was our fly in, fly out medical oncologist and I was the manager of cancer and palliative care services and now Director of Cancer Services Innovation, so yes, it is difficult.

The Hon. COURTNEY HOUSSOS: Who was the supervisor of Dr Grygiel when he was operating as a fly in, fly out specialist?

Mr McLACHLAN: My sense is it would have been the Director of Medical Services in that facility at the time as a senior doctor and the nursing unit manager is the coordinator of the other clinicians in the team.

The Hon. COURTNEY HOUSSOS: Did he have contact with junior doctors? Was he training people through this process as well?

Mr McLACHLAN: Ms Jones, are you able to answer that?

Ms JONES: No, he did not; he was not training junior medical officers. He may have had some contact in that he did see inpatients at the time, and he may have engaged with junior medical officers when he saw a patient at the hospital in Orange or Bathurst.

The Hon. COURTNEY HOUSSOS: It seems that concerns were raised at St Vincent's Hospital through interactions with junior doctors or pharmacists. I appreciate that in the Central West the prescriptions were largely filled at local pharmacies and not necessarily at hospital pharmacies in the same way that they were at St Vincent's Hospital. He was not training local doctors, he had limited contract with junior doctors, and we have heard from the nurses with whom he had interactions that he was not really the kind of person who liked people raising concerns about his practices. Given that the local data covers only from 2010 to 2013, have you requested the Pharmaceutical Benefits Scheme [PBS] data or any other information between 1989 or 1990 and 2010 to ascertain more information? The Committee has heard a great deal about the lack of recordkeeping. It appears that Dr Grygiel was acting like a renegade. There was no supervision or interaction with local doctors.

Ms WYKES: In terms of the records, the sample included cases from 2006, which is covered by the inquiry's terms of reference. We are still not aware of how far the PBS data will go back.

The Hon. COURTNEY HOUSSOS: When you requested the PBS data, what exactly did you want?

Ms WYKES: I would have to check those details with Ms Jones. The request that has been acted on is not the request we made.

The Hon. COURTNEY HOUSSOS: I am sorry; that is correct.

Ms WYKES: We made a request that was not acted upon, and the section 122 inquiry took up the baton and made its own request. I cannot answer about what it involved.

The Hon. COURTNEY HOUSSOS: Ms Jones, do you have any information about the actual request lodged by the PBS?

Ms JONES: I phoned the PBS, and they explained to me that normally they would not release that data. They said that only a patient or a prescriber can request that information. I was told that because we were a third party I would need to make a request by email, which I have done, but I have not received any further response.

The Hon. COURTNEY HOUSSOS: Do you think we will ever know the true extent of underdosing in the Central West?

Ms JONES: I think that once we get the PBS information we will know a lot more. As Ms Wykes said, we do not know what the section 122 inquiry specifically asked for, so I am not in a position to answer that question.

The Hon. COURTNEY HOUSSOS: Perhaps Mr McLachlan would like to answer from a global perspective. Do you think that we will ever understand the true extent of underdosing in the Central West?

Mr McLACHLAN: I think we have done a lot of things in looking back on practices, looking at data, and trying to understand the scale of the issue. The PBS data will give us greater insight into what was prescribed outside of our system and help us to understand what else we need to do to support patients.

The Hon. WALT SECORD: The question is simple: Do you think that we will ever truly know the extent of underdosing in the Central West by Dr Grygiel? Because of the poor recordkeeping by the local health district and Dr Grygiel's actions, do you think we will ever know?

Mr McLACHLAN: I think we are doing everything we can to understand the scale of the issue and to ensure we can reassure patients.

The Hon. WALT SECORD: So the answer is no.

Mr McLACHLAN: I am happy to keep looking for other opportunities for regional patients—

The Hon. WALT SECORD: So the answer is no.

The CHAIR: Order! The witness has answered the question.

Mr JEREMY BUCKINGHAM: Dr Grygiel had been operating in the Central West for a generation. Is it the LHD's and its predecessor's position that, apart from perhaps one diarised entry, there are no recorded concerns about his attitude and his practices?

Ms WYKES: When this came to light in February, we went through a process to see if we could identify whether we had records of incidents. We analysed our complaints and found that we had one from a family in 2006. Dr Grygiel did not engage in that process to the extent that we would have liked, and we assisted that family to contact the Health Care Complaints Commission. We directed them in that way. That is the only complaint—

Mr JEREMY BUCKINGHAM: It was a formal complaint?

Ms WYKES: Yes, that is correct. I also went through all the clinical incidents archived in our incident management system, and our acting patient manager analysed them for any mention of Dr Grygiel's name, and then reanalysed them to see whether there was anything that indicated a concern about prescribing. We did not identify any incidents.

Mr JEREMY BUCKINGHAM: Mr McLachlan, you said that there were discussions. You are relatively new in this position. How long have you been the executive officer of the LHD? How did you form that view? How did you find out there were discussions between or concerns on the part of clinicians about, as you said, Dr Grygiel's "abrupt manner" and his attitude when he was questioned? How did you form that view?

Mr McLACHLAN: I started in this role on 7 January 2013. I became aware of the issue after the *7.30* program was broadcast, and I started to understand more deeply the role that Dr Grygiel had played in the region over the years and the concerns. I also spoke to Ms Jones and Ms Wykes, who had some understanding of his behaviour and practices. Those are the questions I asked when we became aware.

Mr JEREMY BUCKINGHAM: How did the capecitabine issue come to light? How did that emerge in Dr Currow's report?

Ms WYKES: My understanding is that the local oncologist identified several incidents involving capecitabine. The section 122 inquiry came back to me—

Mr JEREMY BUCKINGHAM: When you say the "local oncologist", who do you mean?

The Hon. TREVOR KHAN: I presume it was Dr Zielinski.

Dr ZIELINSKI: There is more than one of us, which is fantastic. Dr Peter Fox is the other oncologist. He assumed the vast majority of Dr Grygiel's colorectal cancer patients because he started two months before I did. He started in February 2013 and I started in April 2013. My understanding from talking Dr Fox is that he noted a couple of patients—I cannot provide the exact number—who he thought did not get the proper dose of capecitabine according to the protocol.

Mr JEREMY BUCKINGHAM: Did he become aware of the section 122 inquiry of his own volition?

Dr ZIELINSKI: No, this was prior to the section 122 inquiry. It would have been in 2013.

Mr JEREMY BUCKINGHAM: So, Dr Fox raised issues about capecitabine in 2013?

Dr ZIELINSKI: No, this came to light after the section 122 inquiry. In 2013, he would have identified one or two patients who he felt had not been given the appropriate dose of capecitabine. However, it is hard for us to determine that because there are some good reasons for using a low dose, for instance, DPD deficiency. If you give a high dose in that case you will harm the patient. That was probably one or two patients out of several hundred, so Dr Fox would not have felt that there was a systemic problem. It is only since the section 122 inquiry that that would have triggered a memory, "Hang on, I saw something—

Mr JEREMY BUCKINGHAM: So he never raised those concerns formally with anyone?

Dr ZIELINSKI: Correct.

Mr JEREMY BUCKINGHAM: But then, because of the section 122 inquiry, he found out about it. Was he formally approached by the LHD to make a submission or to participate?

Ms WYKES: So Dr Fox was on the list of people for the section 122 inquiry to speak to. That is where he spoke to them about that. The section 122 inquiry came to me and said could I speak with Dr Fox to get the details of those patients. He could not recall individual details so I presume that obviously they made their identification through the information that was provided from the chemotherapy prescribing company and also through the sampling that they did.

Mr JEREMY BUCKINGHAM: Did the section 122 inquiry talk to all oncologists that had been working with the health district and associated with Dr Grygiel in his whole history in the Central West? Why did the section 122 inquiry just go to Dr Fox?

The Hon. TREVOR KHAN: That is not the evidence.

Ms WYKES: I believe that Dr Rob Zielinski spoke to them as well.

Dr ZIELINSKI: Yes, we did—absolutely.

Ms WYKES: Otherwise you would probably have to go back to them as to who they chose.

Mr JEREMY BUCKINGHAM: But have they spoken to everyone? Do you know that?

Dr ZIELINSKI: They spoke to me and the radiation oncologist as well.

Mr JEREMY BUCKINGHAM: But are there other oncologists that have been working here that may not have given—

Dr ZIELINSKI: I do not believe so. After Dr Grygiel resigned in 2012, as Ms Jones said, there was some Telehealth. They would not have worked with Dr Grygiel. Then in 2013 Dr Fox and I took over his patients.

Mr JEREMY BUCKINGHAM: But Dr Grygiel has been operating here since 1989.

Dr ZIELINSKI: Yes, but he was the only oncologist during that period.

Mr JEREMY BUCKINGHAM: In the whole Central West?

Ms JONES: He was the only oncologist for Bathurst and Orange. The section 122 inquiry gave us a number of groups of people for which they asked us to provide the names and we provided that information back in May. They selected people for interview and let us know in May who they would like to interview.

Mr JEREMY BUCKINGHAM: Okay. That is interesting. Could you provide those names to the inquiry?

Ms JONES: The list of names submitted?

Mr JEREMY BUCKINGHAM: Yes.

Ms JONES: Absolutely.

Mr JEREMY BUCKINGHAM: Thank you.

The Hon. WALT SECORD: Who determined who would be interviewed?

Ms JONES: My understanding is that that was the section 122 inquiry. Ms Wykes?

Ms WYKES: I believe my recollection, Ms Jones, was that they asked us for categories of people. We provided a list of people and they made a selection based on that.

Dr ZIELINSKI: Can I just say that Dr Fox and our district should be congratulated for identifying the capecitabine cohort, because that did come from our area. I just wanted to make sure that Dr Fox was not being maligned in any way.

The Hon. WALT SECORD: No.

Mr JEREMY BUCKINGHAM: That is certainly not the case, Dr Zielinski. I am interested in how the section 122 inquiry set the number, further to the Hon. Walt Secord's questions. Is it the case that every single person in this area who may have received carboplatin has actually been assessed as to whether or not they received the appropriate dose?

Ms WYKES: For carboplatin?

Mr JEREMY BUCKINGHAM: Yes.

Ms WYKES: We have reviewed all the prescriptions that have been made available by our chemotherapy pharmacy company—

Mr JEREMY BUCKINGHAM: Because you do not—

The Hon. TREVOR KHAN: Just let her answer.

Mr JEREMY BUCKINGHAM: I know that that is the same answer that was given before, because you have got—

The Hon. TREVOR KHAN: Just let her answer.

Ms WYKES: Because there was not an electronic prescribing system, the only way that we can get a list of drugs—and because that was an intravenous drug—would have been through our pharmacy provider. Their records only go back to the end of October 2010 so we took it to the end of 2013 and we have reviewed every carboplatin prescription provided by our company that is available.

Mr JEREMY BUCKINGHAM: So because the records do not exist we do not have the records of all those people and we cannot say whether they were flat dosed in that period from 1989 up to 2010—we do not know.

Ms WYKES: Because it is a hard copy paper record, it is not electronic, so we cannot extract that information.

Mr JEREMY BUCKINGHAM: So we do not know how many people may have been or may not have been under dosed or off-protocol dosed or given the same dose—that 100 milligrams of carboplatin—between 1989 and 2010. We just do not know. Can we never know?

Ms WYKES: We are not able to based on drawing data on prescriptions for carboplatin.

Mr JEREMY BUCKINGHAM: The interesting issue that emerged from the section 122 inquiry was around colorectal cancers and capecitabine. In finding 55 of the section 122 inquiry report it says "no anomalous patterns were identified" with any other cancers or any other medications. Can you assure this inquiry and the people of New South Wales that is absolutely the case?

Ms WYKES: The section 122 inquiry report did not identify any anomalous patterns of prescribing. Based on the people who have contacted us, we have not found any other patterns either. That is the advice from our oncologist who has reviewed those cases for the people who have contacted the local health district through the inquiry line or come to light in ways other than the section 122 inquiry.

Mr JEREMY BUCKINGHAM: I have been contacted by someone who has suggested that there may be a pattern of this type of prescribing in breast cancers. Did you assess breast cancers and Dr Grygiel's treatment of breast cancers in your investigations under the section 122 inquiry?

Ms WYKES: We did not investigate under the section 122 inquiry. The inquiry did that investigation.

Mr JEREMY BUCKINGHAM: The inquiry did the investigation?

The Hon. TREVOR KHAN: Just let her answer the question.

Mr JEREMY BUCKINGHAM: I can ask questions, thank you, the Hon. Trevor Khan.

The Hon. TREVOR KHAN: Yes, and you can do the witness the courtesy of allowing her to answer the questions.

Mr JEREMY BUCKINGHAM: You can do her the courtesy of being quiet, the Hon. Trevor Khan.

The CHAIR: Order!

Mr JEREMY BUCKINGHAM: When you say the section 122 inquiry did the inquiry, are you saying they did the inquiry into breast cancers in this LHD?

Ms WYKES: They evaluated the information for carboplatin and the capecitabine that we have discussed and they did the sampling. In the sample they reported in the report that no anomalous prescribing pattern was identified.

Mr JEREMY BUCKINGHAM: That is for those medications, but they are for breast cancers—

Ms WYKES: The sample was across all—it was a sample.

Mr JEREMY BUCKINGHAM: Of all cancers and all medications?

Ms WYKES: It was the sample of all the patients that Dr Grygiel saw in western New South Wales.

Mr JEREMY BUCKINGHAM: For whatever cancer it may have been?

Ms WYKES: Yes.

Mr JEREMY BUCKINGHAM: And there were no anomalies?

Ms WYKES: That is the report—yes. We did not do the reviews for the section 122 but I understand the sample involved was a random sample and they did the analysis.

Mr JEREMY BUCKINGHAM: How many hundreds of people were in that sample in those other cancers and those other medications?

Ms WYKES: In terms of the section 122 inquiry report basically you have got what we have got. They did not identify the numbers of different tumour streams or anything like that in the report. I would just have to go back to the numbers which would be in the report, but it was approximately 50 in Bathurst and 62, I

believe, in Orange, which constituted the random sample. That was based on the number of new patients that Dr Grygiel saw from 2006 to 2013 for the term of the terms of reference.

The Hon. WALT SECORD: Mr McLachlan, in light of remarks just made by your colleague Ms Di Wykes, do you reassess the observation that I put to you? Do you think that we will never truly know the extent of under dosing in the Central West—in Orange and Bathurst—especially between 1989 and 2010? Do you think we will never truly get to the bottom of this?

Mr McLACHLAN: It is a long time back to 1989. We understand that patients and families will be concerned about their care. We have opened up a lot of avenues for us to both look into the dosing of the type of care that was provided, to provide opportunities for patients and families to come forward and talk to us.

The Hon. WALT SECORD: My question is very simple. Do you think that we will ever truly get a picture of what happened here in the Central West because of poor record keeping, the random sampling and people not giving evidence to the inquiry and the lack of material? Will we ever truly get to the bottom of this?

Mr McLACHLAN: I would have to wait to see the PBS data. I think that is going to be the next piece of information that helps us understand what we can look into, and, as I said earlier, we do not have that data yet.

The CHAIR: I think it is very important, Dr Zielinski, that cancer care from the 1980s to where it is now has come leaps and bounds, would that be fair to say?

Dr ZIELINSKI: Yes, absolutely. We are pretty proud of what we have done since arriving. We have got a clinical trials unit, which adds a lot of scrutiny and order to our practice; we send nurses to conferences; we have education meetings now all the time. These are all the benefits and values of having resident oncologists.

The CHAIR: You have just got to do some things about system failures, by the sounds of it.

The Hon. BRONNIE TAYLOR: When was MOSAIQ introduced in the LHD—your electronic auditing system?

Ms JONES: It was a staged implementation of MOSAIQ that commenced in February 2015. We obviously had a number of sites that we had to cover and we also began with the scheduling and nursing assessments, followed by the prescribing across the district.

The Hon. BRONNIE TAYLOR: So MOSAIQ was not implemented until after Dr Grygiel had finished being a visiting oncologist?

Ms JONES: That is correct.

The Hon. BRONNIE TAYLOR: So there was no electronic mechanism for the flagging of a dose that was way outside the eviQ standards?

Ms JONES: That is correct.

The Hon. BRONNIE TAYLOR: When we talked about complaints, and Ms Patterson, you talked about that amazing Anson Cottage and that you got some complaint from there, I am just wondering, looking forward in terms of governance, that we need to perhaps have—would you agree and please comment—some other mechanism rather than what has been in place before? Because I would find it hard to believe that it has not been flagged about a dosage before, with the expertise of the clinicians that you have in your facilities delivering this treatment.

Mr McLACHLAN: Ms Taylor, I am happy to start and I might hand over to Dr Zielinski to follow up. I think the implementation of MOSAIQ has transformed our ability to put in place some safeguards, have good document and record keeping and allow clinicians to get together on a regular basis and have a conversation about their practice and reflect on the way that they prescribe and coordinate care for patients. I think the solution in MOSAIQ gives us an amazing ability to have that conversation across multiple sites as well. So in developing a cancer centre in Dubbo, which has recently been announced, it is still a couple of years away but it will transform that north-west part of our region as well.

We have just recruited our first medical oncologist into Dubbo—that is a young medical oncologist that I think will be the core of our oncology services for a lot of years into the future. He has headed up the team of oncologists looking into that monthly review. He spent a lot of time analysing the data for the first time, helping us grow some procedures around the data that comes out of MOSAIQ, how we analyse that, and we have conversations amongst the clinicians. I might ask Dr Zielinski to talk a bit about MOSAIQ, how we escalate issues and deal with those across the district.

Dr ZIELINSKI: As you guys are well aware, having an electronic system is not the solution, it just gives you the tool to obviously bind these issues. MOSAIQ is a great tool but we have got an oncology pharmacist in each site and I think that is probably an equally important part which was not around before 2014, I think was when the pharmacist started. So that is the key part. I echo Scott's comments that having these conversations—and I have been asked already in the last three or four months since we got this monthly review in about certain prescribing habits of mine. I welcome those; I explain it to them; I do not feel threatened by it. I think we are having good conversations now that were not happening previously.

The Hon. BRONNIE TAYLOR: Following on from that, would you say, Dr Zielinski and also Mr McLachlan, that your governance over your specialist medical practitioners is going to be a lot stronger when you have resident practitioners, and how are you going to make sure that with visiting practitioners that that governance is very much strengthened? Because I think that is one of the core issues here, is it not?

Dr ZIELINSKI: Yes. We have got a fly in, fly out haematologist that comes to Orange as well. So we are already, I think, embodying that process you are talking about. They are very keen and eager to comply with what we have decided as the group of resident oncologists what the standard should be. I think I am comfortable saying that we have already integrated our fly in, fly out haematologist into this model.

Mr McLACHLAN: Could I pick up three things? First of all, we have formed a clinical stream across the whole of our region for all cancer services. That means that medical nursing and allied health clinicians get together on a very regular basis and talk about how we coordinate those services. Secondly, we have just approved another $1.5 million investment in new medical oncologists, haematologists and nursing staff to grow the capability of our services to reduce the reliance on fly in, fly out services. I think that will still be some time in Dubbo, but this will provide a second medical oncologist in Dubbo. I think, as Dr Zielinski has just outlined, the role of the oncology pharmacist is incredibly critical in all of this; so there are extra oncology pharmacists we will be employing into the future—those jobs are about to be advertised. So I think, going into the future, we have got a lot more capability to be reliant on our clinicians in the region and not fly in, fly out services.

Dr ZIELINSKI: And to add to that, the culture that we have got in our cancer centres now I think is different. I regularly get questioned by nurses about doses and admissions, or maybe supportive medications. I grew up in a time where that was normal.

The Hon. BRONNIE TAYLOR: And that is a really positive thing. It is that questioning because that is how we get better and we do a better job. Just two other questions. An issue about performance reviews has come up across the inquiry. Are medical specialists having regular performance reviews from peers or from the person that is above them?

Mr McLACHLAN: I am happy to comment first of all. Two groups of doctors, both our staff specialists and our visiting medical officers—visiting medical officers go through a process every five years of being reappointed to their roles. Within that process there are two levels of performance review and assessment. On an annual basis our staff specialists do have a performance review with their next-in-line manager. That is growing across the region. We recognised a couple of years ago this was not as tight as it needed to be. It is something we have put a lot of effort into. Particularly in Bathurst and Orange, I know the directors of medical services spend a lot of time every year having performance reviews with all of their doctors.

The Hon. BRONNIE TAYLOR: I have one final question—it is more a point of clarification, I think, so I am happy for whoever to comment. When we talk about the capecitabine and the oral dose—the tablet, the capsule—what would happen, I imagine, is that a prescription was written but then that prescription was filled outside the local health district. So it would not be within normal expectations that you would have any record for that, but the records will be where the prescription for capecitabine, for the cetuximab, was filled, and that would be at an outside pharmacy, and that is the information that you are waiting on?

Mr McLACHLAN: Correct, yes.

The Hon. TREVOR KHAN: You were asked about the procedure that followed 18 February. When, if ever, did you make a formal notification to the Ministry of Health of an incident?

Mr McLACHLAN: The first conversation with them was the day after the *7.30* report.

The Hon. TREVOR KHAN: I accept that. Was it done by way of a formal notification?

Mr McLACHLAN: Not in this instance. We classified it as an MCCC process, the management of a complaint against the clinician. It is something we started dialogues and talked to the ministry on a daily basis about. I think that was the best way to deal with this, having an open dialogue about how we deal with it and what is the scale of the issue for us and escalating it that way.

The Hon. TREVOR KHAN: So if there is an incident in your health area, is there a standardised protocol that applies in terms of notification?

Mr McLACHLAN: Absolutely.

Ms WYKES: If it is a management of a complaint or concern about a clinician, then we are obliged, depending on the criteria that it meets, to let the director general know, or the secretary, which we do through the Ministry of Health—only for a certain level. If it is a clinical incident that has occurred where a patient has particularly been harmed and we apply a severity assessment code for that, and then requirements around reportable incidents briefs step in, or come into play. And if they are a clinical severity assessment code one [SAC1] incident it must be recorded to the Ministry of Health via a reportable incident brief. There is legislation around a SAC1 incident and what needs to happen there. In our local health district for a SAC2 incident we also require a reportable incident brief that meets that criteria and we monitor those through the clinical governance unit and we report them to our board committee.

The Hon. BRONNIE TAYLOR: The Committee has received the facts and the Ministerial audit. Yesterday the Committee received evidence from the department about your reporting system that someone can go into, for example, if a clinician was concerned about what was going in with the treatment by Dr Grygiel. I understand in the Murrumbidgee Local Health District will be the first one a clinician can go into. Will you get such a system and when? It will enable people who make complaints not to be targeted or victimised, for example, nursing staff who may see an abnormality?

Ms WYKES: Just to note that the incident management system now has that ability. So people can make anonymous complaints

The Hon. BRONNIE TAYLOR: Since when?

Ms WYKES: Since the end of 2004, November. You can make a notification anonymously in terms of management. That ability is there now. It is difficult to manage when you are anonymous because you cannot talk to the people, find out more details and the circumstances to be appointed.

The CHAIR: Ms Nowlan will you reply to that question of how that system works? I know that you are more than qualified to provide a breakdown.

Ms NOWLAN: Within the incident information management system anybody can enter. You just go into the system and fill in the respective aspects of the information system, and you do not actually have to give your name. That is not a compulsory part to it.

The CHAIR: Are your referring to any health practitioner can do that, not just those employed by the hospital?

Ms NOWLAN: This is within NSW Health anyone can go into the incident information management system and make a notification about whatever it might be. From there they usually fill in SAC assessment score. So if that were to be a SAC2 or a SAC1 I immediately get a notification into my email to alert me to look in the system for what that might be. So that is an immediate escalation of concern within the organisation. If it is not a SAC1 or a SAC2, it is a three or a four, it would go to the next line manager. So the nurse unit manager or the head of domestic services, or security, or whatever it might be that it relates to. That person would then commence the investigation at that level. But if it is a one or a two then I commence a process immediately with that. That is within the organisation on a daily 24:7 process.

The Hon. BRONNIE TAYLOR: I understand that but obviously something has not been right and those notifications did not come in. Something is not working there. How many SAC1, SAC2 do you have?

Ms NOWLAN: Di has got that information for you.

Ms WYKES: For 2015 calendar year we had 12 clinical SAC1s and 96 clinical SAC2s. We also have the option now that if we are concerned about a severity assessment code incident we can escalate that to a root cause analysis [RCA] process. The legislation requires if you have got a clinical SAC 1 incident you must undertake a root cause analysis process. We did for the 12 clinical SAC1s and we also had the option to do that for some SAC2s, and we did it for two SAC2 incidents as well.

Dr ZIELINSKI: As a working clinician in the system, I think, the information management system [IMS] is a great system and it does empower us as clinicians. I have raised SAC2 and I find it empowering because I know that these guys have to act. So that is a great thing as a clinician treating patients. Obviously the issue is education, awareness of the IMS, making it less cumbersome and those sorts of things. Mr McLachlan can probably talk about the education side of it. I think the actual IMS system is good for us as the clinicians, no question.

The Hon. TREVOR KHAN: In what sort of circumstance would you raise an incident?

Dr ZIELINSKI: Usually a near miss. It would be something catastrophic has not happened. An example would be a patient who did not receive antibiotics at a smaller hospital for a febrile neutropenic episode. That is a really dangerous situation. The patient walked away fine and safe from it, but I want the system, I want these guys to actually look at the process so we can improve it.

The Hon. BRONNIE TAYLOR: Respectfully it is a good system, but this time it did not work.

The Hon. NATASHA MACLAREN-JONES: I refer to record keeping. Electronic record keeping was introduced in 2015? Prior to that it was all paper records. Were they kept on site at hospitals and for how long?

Mr McLACHLAN: I might ask Ms Nowlan and then Ms Patterson to answer that.

Ms NOWLAN: In relation to the paper-based records, at Orange Anson Cottage was the location of our Cancer Centre. They would have kept those records over there. They would have followed the respective requirements under policy for the duration of which a record is required to be kept and stored for.

The Hon. TREVOR KHAN: What is that period of time?

Ms WYKES: The retention period for a medical record generally is 10 years. However, because of the royal commission into sexual abuse of children there has been a moratorium on the destruction of records, and I would have to clarify the exact time.

Ms NOWLAN: While a patient was active their record would be stored at Anson Cottage. When records were completed the Health Information actual unit was located over at the old Orange Hospital. We have had a significant number of changes then. We went to a process where we could not actually keep all our records on-site and we went to a process where we scanned in records, like an electronic process, and then we have gone to a process where they are off-site storage under a contract where they are not held at that facilities.

The Hon. NATASHA MACLAREN-JONES: Over the 10 year period if a patient now—so the records are 10 years old—came back into the hospital are their previous records scanned in or what? Are they kept on the MOSAIQ system?

Ms PATTERSON: As new records, yes, they are kept on the MOSAIQ system. Their previous record we would pull up from our Grace document storage and have it scanned back into our clinical patient folder [CPF].

The Hon. TREVOR KHAN: What does that mean in terms of assessing the material through MOSAIQ?

Ms PATTERSON: With the new patient record in MOSAIQ everything is available. But the old record it will be scanned in to a different system called CPF, clinical patient folder. So everything can be accessed electronically, you just pull up a dual screen computer and can look at both documents simultaneously.

Dr ZIELINSKI: I just want to provide a bit of context. We have had an electronic medical record system for a lot of our general inpatients and emergency departments for a number of years now. We are now the first district across the whole of the State to have health coverage of every hospital, every emergency department, inpatient service and community health service.

Mr McLACHLAN: When Ms Patterson talks about "CPF", it is a good scanning solution that allows us to scan paper-based documents into the system. We still have a long way to go to scan in all of the historical records going back 10 years. It is about a couple of million dollars worth of investment. We have talked to Grace and others about doing that. It is something that we to do when we need to retrieve a document or a record; we scan it into that system so that we have it available.

The Hon. NATASHA MACLAREN-JONES: In relation to the documents over the past 10 years, if a patient wanted to access their records, can they and what would be the process?

Ms WYKES: Absolutely they can. We would retrieve the record and we would provide it either as hardcopy or scanned.

The Hon. TREVOR KHAN: Is a document searchable if it is scanned?

Ms WYKES: It is scanned in PDF format.

The Hon. TREVOR KHAN: Even I understand that.

Ms WYKES: It might be flagged that it is an oncology record or an outpatient record. It is not searchable.

Dr ZIELINSKI: To clarify, you could not search it like you do a Google search. However, the records are categorised. It might be a histopathology report, a chemotherapy prescription and so on. There would be certain parts of the record that could be found easily.

The Hon. WALT SECORD: Dr Zielinski, I understand that you were a young doctor here in Orange, that you went back to Sydney, and then you came back again. When did you return to Orange as an oncologist?

Dr ZIELINSKI: In April 2013.

The Hon. WALT SECORD: In assuming your duties with Dr Fox, did you assume some of Dr Grygiel's patients?

Dr ZIELINSKI: Yes. As I said, Dr Fox would have got the majority of the patients because he started two months earlier. I have some of Dr Grygiel's patients now.

The Hon. WALT SECORD: Many of them?

Dr ZIELINSKI: No, not many. I could not give the Committee an exact number, but it is not many.

The Hon. WALT SECORD: When you assumed your duties and Dr Grygiel's patients, was there a dearth of information? Did your antenna go up?

Dr ZIELINSKI: It was not so much a dearth of information worrying me. I have worked with other specialists where there was not a lot of documentation. When I assume a new patient I go back through the records. The most important things you want to find out are the histopathology of the cancer and what treatment they received. Often you would see a comment about the chemotherapy protocol or the regimen chosen. But I would not and I do not individually drill down for a patient about what dose they got five years ago. This would not have come up regularly.

The Hon. WALT SECORD: So nothing involving Dr Grygiel's patients raised your antenna?

Dr ZIELINSKI: No.

The Hon. WALT SECORD: Have you now drilled down in light of the February *7.30* report? Have you now had conversations with those patients? Are they concerned? What is happening with them?

Dr ZIELINSKI: It would be varied. Obviously as patients come back and I know they were Dr Grygiel's, I ask them the question. Many of them are very well informed and obviously have anxieties. I will check the dose in those circumstances. I must admit that many of them are breast cancer patients and they got the dose that I would have given. Obviously I am acutely aware of this issue now and I go back and check.

Mr JEREMY BUCKINGHAM: I refer to the random sample of patients. How many different tumour streams are there? How many different tumours does the LHD deal with?

Dr ZIELINSKI: Pretty much all of them.

Mr JEREMY BUCKINGHAM: How many would that be?

Dr ZIELINSKI: It would be somewhere in the order of 20. That is the solid organ tumours; I am not counting the hematologic malignancies, which are another group.

Mr JEREMY BUCKINGHAM: At least 20. How many of the cases caught in the random sample did not have records of dosage of various chemotherapy drugs?

Ms WYKES: You would have to go back to the section 122 inquiry to ask that question.

Mr JEREMY BUCKINGHAM: Did you not provide them with that information?

Ms WYKES: We provided them with the records.

Mr JEREMY BUCKINGHAM: So some of the records of the people in the sample may not contain the dose of chemotherapy drugs they received?

Ms WYKES: That is possible, particularly when it involved a prescription for an oral drug. We do not always have copies of prescriptions when patients have them filled elsewhere.

Mr JEREMY BUCKINGHAM: So it is possible, for example in Orange where there were 56 people, that it might cover 10 or 15 different tumours. So three or four people in each tumour group might have been caught, and we may not have records for some of those people.

Ms WYKES: As we said, some records were missing, and we provided alternative—

Mr JEREMY BUCKINGHAM: Do you think that is statistically—

The Hon. TREVOR KHAN: Let the witness answer.

Mr JEREMY BUCKINGHAM: I have one minute left—

The CHAIR: Order!

Mr JEREMY BUCKINGHAM: This is very important. Do you think it is statistically valid to rely on a sample of perhaps as few as one or two people in a cohort and then to conclude that there has been underdosing in an entire cohort?

Ms WYKES: We did not get feedback from the section 122 inquiry that they could not make a judgment in those sample groups, obviously except in respect of the files that were missing, which were replaced with alternatives.

Mr JEREMY BUCKINGHAM: They said that they could not make a judgment about some of those sample groups.

Ms WYKES: You would have to go back—

Mr JEREMY BUCKINGHAM: How can they say that there is no anomaly if they cannot make a judgement?

The CHAIR: Order! Perhaps it would be more appropriate to ask that question of Dr Currow.

Mr JEREMY BUCKINGHAM: I have one more question.

The CHAIR: We are running out of time.

Mr JEREMY BUCKINGHAM: I know we are. Section 24 of the report states:

> In addition, 16 patients or their families contacted the LHD after the media reports in February 2016 and queried the dose of chemotherapy they received. The LHD advised the Inquiry in June 2016 that one of its medical oncologists had reviewed one of the patients; and that the medical records for a second patient could not be located.

This is the important part:

> The Inquiry conducted an assessment of the chemotherapy prescribed to the other 14 patients against the relevant eviQ protocols—

I am sorry, I have been reading the wrong part.

The Hon. NATASHA MACLAREN-JONES: Point of order: Is there a question?

Mr JEREMY BUCKINGHAM: I sincerely apologise. This is very important. Section 29 states:

> This treatment was similar to the pattern of treatment of the patients for whom Dr Grygiel prescribed off-protocol flat dose …Of the remaining 4 patients, the medical oncologist questioned the choice of carboplatin in relation to 3 of them. The fourth received a higher than usual dose of carboplatin.

Who was the medical oncologist who questioned the choice of carboplatin in relation to three of those four patients?

Dr ZIELINSKI: That would have been me or Dr Fox. I cannot remember the specific example.

The CHAIR: You can take the question on notice.

Mr JEREMY BUCKINGHAM: No. How was that questioned? Surely you would remember that?

Dr ZIELINSKI: I remember one patient—

Mr JEREMY BUCKINGHAM: So you questioned the choice of carboplatin for one patient?

Dr ZIELINSKI: I performed the initial audit of the carboplatin patients. I think that is what the member is referring to.

Mr JEREMY BUCKINGHAM: But did you question that then or previously?

Dr ZIELINSKI: Then. At the time that I handed the records—

Mr JEREMY BUCKINGHAM: That oncologist questioned the choice of carboplatin by both you and Dr Fox, and it happened this year—in February?

Dr ZIELINSKI: Yes, I think that is right.

Ms WYKES: Dr Zielinski's letter was dated 1 March.

The CHAIR: We went a little over time. However, time is not the issue as much as the information that the public needs. I have extended the hearing a little to give members more time in which to ask questions. Thank you for appearing before the Committee today. Witnesses have taken some questions on notice. They have 21 days in which to provide answers. The secretariat will provide assistance in that regard. In light of your evidence, members may forward further questions. Once again, thank you for what you are doing. As you said, while this is a challenging inquiry, there is a great deal of good news, particularly with regard to regional cancer treatment; it is going from strength to strength. That is a good news story for New South Wales. This Committee wants to ensure that systemic failures are addressed. We must hold people accountable so that residents in regional areas can have confidence in the treatment they are receiving.

(The witnesses withdrew)

The Committee adjourned at 10.40 a.m.